Acceptable Plan of Correction

Quality and Compliance 54/11 MM Bureau of Health Care Quality and Compliance

PRINTED: 04/11/2011 **FORM APPROVED**

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		A. BUILD		(X3) DATE SURVEY COMPLETED	
		NVS5818AGC		B. WING		03/21/2011	
AMEERY CARE 333 PRING				DRESS, CITY, STATE, ZIP CODE CE GEORGE RD AS, NV 89183			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOULD BE COMPLETE		
Y 000	0 Initial Comments			Y 000			
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.				RECEINMAY 0 3	2011	
	This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted on your facility 3/2/11 through 3/21/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and four employee files were reviewed. The facility received a grade of A.				BUREAU OF LICENSURE AND LAS VEGAS, NET	ADA *	
Y 026 SS=D	NAC 449.190 3. A residential facility may be licensed as more than one type of residential facility if the facility provides evidence satisfactory to the bureau that it complies with the requirements for each type of facility and can demonstrate that the residents will be protected and receive necessary care and services.		W	Resident # 1 was DiscHarged on 3/24/11 Resident # 2 HAD Duel Diagnosis AND CAREGIVER HAD PROPER TRAINING CAREGIVERS WILL BE TRAINED ON ALTHERMES AND MENTAL ELLNESS TO ENSURE PROPER CARE.			
	Based on observat	not met as evidence ion, record review an , the facility was carir	d		c) 3/24/11		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/21/2011 NVS5818AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 333 PRINCE GEORGE RD **AMEERY CARE** LAS VEGAS, NV 89183 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) Y 026 Y 026 Continued From page 1 10 persons with mental illnesses without an endorsement and failed to obtain the necessary training to care for such persons (Resident #1 and #2). Severity: 2 Scope: 1 EXIT DOORS WILL BE EQUIPPED WITH LOCKS THAT DO NOT REQUIRE Keys.

Key Locks have been replaced Y 445 Y 445 449.229(3) Exit doors SS=F NAC 449.229 WITH PROPER LOCKS FOR Keyless 3. An exit door in a residential facility must not be equipped with a lock which requires a key to open EXITING . it from the inside unless approved by the State See ATTAChmenT # 1 Fire Marshall or his designee. ADMINISTRATOR WILL MONITOR FOR Compliance c) 4/15/2011 This Regulation is not met as evidenced by: Based on observation, the facility failed to ensure 1 of 2 primary exits was equipped with a lock that could be opened from the inside without a key (front door). Severity: 2 Scope: 3 a) The FACILITY WILL ENSURE THAT Y 878 449.2742(6)(a)(1) Medication / Change order SS=D ALL RESIDENTS WILL RECEIVE Their medications as prescribed. NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a b) Resident medications will Be physician must be administered as prescribed by OBTAINED IMMEDIATELY Upon the physician. If a physician orders a change in ADMITTANCE TO The FACILITY. the amount or times medication is to be Residents NOT HAVING ACRESS administered to a resident: If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. If continuation sheet 2 of 3 92FX11

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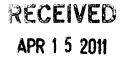
Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 03/21/2011 NVS5818AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 333 PRINCE GEORGE RD **AMEERY CARE** LAS VEGAS, NV 89183 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) To their medications, OR NOT Y 878 Y 878 Continued From page 2 ABLE TO OBTAIN PRESCRIBED (a) The caregiver responsible for assisting in the Medication will be DISCHARGE administration of the medication shall: FROM The FACILITY. MEDICATION WAS PURCHASED CFACILITY) (1) Comply with the order. RESIDENT # 1 WAS DISHARGED From the FACILITY on 3/25/2011 WITH A SAFE DISCHARGE See Attachment # 2 This Regulation is not met as evidenced by: c) 3/25/2011 Based on interview and record review from 3/2/11 through 3/21/11, the facility failed to ensure that 1 of 10 residents received medications as prescribed (Resident #1). This is a repeat deficiency from the 10/8/10 complaint investigation survey. Severity: 2 Scope: 1

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